ISSN 2457-063X (Online) **www.ijisms.com** *Volume: 4 Issue: 3 | 2020*

Long-term Effects of the Treatment of Bipolar Disorder

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Abstract: *Hypomanic symptoms prompts the diagnosis of Bipolar disorders when careful assessment is carried out on an individual by a clinician. This is an illness that dates back in ancient Greek and Roman civilization, where the concept of manic and the term maniac originated. The provocative nature of bipolar disorder illnesses are mutable as time passes (Healy, 2008).The severity and patterns of any depressive symptoms require inquiries by a clinicians in establishing the importance of debilitating the bipolar disorder impact. Normal mood states frequencies provide the basis for clinicians to review the severity of depression and mood change. In a case of bipolar I disorder diagnosis, one episode may be prevalent with the tendency social or occupational impairment, but the individual perhaps may not necessarily be depressed of experience psychosis symptoms. In the case of bipolar II, diagnosis, at least one major depressive and hypomanic episode is prevalent. In the case of Cyclothymic disorder, impairment results from milder hypomanic symptom, which can linger for with mild depression for at least two years.*

This papers examines some effects in the bipolar disorder treatment, taking into consideration the biomedical as well as psychosocial factors, and how both factors relate to the history of the illness.

Keywords: *Bipolar, disorders, clinician, Hypomanic, depression, psychosis, impairment.*

Introduction

Bipolar is referred to a group of affective disorder with the characterization of depressive and manic or hypomanic episodes(Philip and Kupfer, 2013).As much as depression is a symptom of bipolar disorder, bipolar disorder and depressive disorder are not similar in condition (Sue et al, 2016). Genetic component cannot be dissociated with bipolar disorder due to the strong tie both have. Psychological overlap is strongly evident in biological etiology between bipolar and schizophrenia. Schizophrenia is a severe illness of mental health that is associated with loss of contact with reality (Sue et al, 2016). Depressive orders as a result of bipolar disorder in some people, can be addressed with the medication. Bipolar disorder tend to begin at early age in people, between teenage years and in their twenties, depressive others on the other hand begins in late twenties for many people. The frequency of occurrence of bipolar disorder is mush lesser than depressive disorders (2016). The following are the various diagnostic classes of bipolar disorder and their explanations:

- **Bipolar disorder type I** – This is a depressive, one manic episode diagnosis that occur in an individual with or without a history of severe depression. This is diagnosed when one manic symptom significantly affect normal functioning. It occurs mostly in the day, nearly every day and can stretch for a full week. In this manic episode, interpersonal interactions are significantly affected by interfering with common activities. Psychotic symptom or hospitalization are the resultant effect of the uncharacterized features of the manic episode (2016).
- **Bipolar disorder type II** –Difficulty of differentiation makes bipolar disorder type II to be diagnosed from recurrent unipolar depression in depressed patients (Philip and Kupfer, 2013). The symptom can last for two week, and characterized by at least one hypomanic episode which can be visible for at least 4 consecutive days. Individuals with bipolar disorder II often allow the illness to degenerate seriously and fail to seek treatment until their mood swing and their depressive state becoming overwhelming (Sue et al, 2016). Bipolar disorder II is heavily characterized by depression and family members are always the first to notice it. Due to physicians' inadequate assessment and under diagnosing of the bipolar disorder II, ineffective anti-depressants are prescribed which could prolong the treatment process. (2016).What differentiates bipolar I and bipolar II is the severe nature of the symptom during energized episode. Bipolar I needs one manic episode to be diagnosed while one major depressive episode and one hypomanic episode is required in bipolar II (APA, 2013).
- **Cyclothymic Disorder** – It's a milder hypomanic symptom that involves impairment in the functionality of the individual. The individual can expressed mild depressed mood for a period of 2years (Sue et al, 2016).Persistent depressive disorder (dysthymia) is similar to cyclothymic disorder due to the chronic mood symptoms. When cyclothymic disorder is diagnosed in an individual, he or she may eventually meet the criteria for bipolar disorder II when their mood symptoms are heightened (APA, 2013).

DSM V TR criteria for diagnosing Bipolar Disorder

In affective disorder evaluation, the DSM V criteria is used for affective episode when the individual exhibits any three the following symptoms according to Sue et al (2016):

- Symptom of self-importance
- Desire for more sleep and to rest more
- Talks without taking a break
- Ideas and topic change easily
- Giving unimportant environmental stimuli attention
- Increased social or work-related goal-directed activity, sexual activity, or physical restleness
- Engaging in activity that have negative consequence (e.g., excessive spending, sexual promiscuity, gambling).

Treatment for Bipolar Disorder

Biomedical Treatment

Recent development have emerged bipolar disorder long treatment. The most modern form of treatment form has become the drug treatment which is also referred to as biomedical treatment. Geddes and Miklowitz, 2013). Despite the wide use of antidepressant drugs in managing depressive episode, there are still uncertainties and controversies surrounding the treatment, as it concerns the long term benefits of antipsychotics.

In manic symptom, the use of Lithium and chlorpromazine has been found to be strong for relapse prevention in long term (2013),although evidence still showed through research that antipsychotic drugs seem better than anticonvulsants and lithium in the treatment of manic episodes. Some of the best available drugs for manic treatment are Olanzapine, risperidone, and haloperidol.

In the treatment of bipolar depression, research by Geddes and Miklowitz (2013) showed scarce evidence for efficacy in the use of antidepressant. Due to the phenomenologically and biologically of bipolar depressive episode (2013). After administering antiepileptic drug lamotrigine, a clinical benefit was observed for patients with bipolar depression but no statistically significant result in use of lamotrigine in acute treatment, therefore it remains uncertain based on a meta-analysis of individual patient carried out for five trials of lamotrigine. The investigation reported a modest effect of the treatment.

Psychosocial Treatment

Social adjustment functioning may significantly help patient with bipolar disorder to avoid hospitalization as an adjunct to standard medications (Gutierrez and Scott, 2004). History had it that psychological therapies to bipolar disorder are not effective because of the idea that the illness is primarily biologically determined (2004), but stress diathesis model increase has proven the narrative to be wrong, with the application of a number of large scale randomized controlled trials (RCTs). The following are the psychosocial treatment:

- **Psychoeducation** - This empowers the patient by providing a practical and theoretical approach to understanding and dealing with the symptoms and consequences of bipolar disorder. According to Vieta in Journal of clinical psychiatric (2005), Psychoeducation identifies bipolar disorder as a biological abnormality that requires regular pharmacologic treatment and teaches patients to cope with symptoms and maintain regularity in daily social and occupational functioning
- **Family Focused Therapy (FFT)**–Patients in the families tend to have fewer mood disorder relapse due to support they receive. This is a useful adjunct to pharmacotherapy and hastens episodes. Patients and their families are encourage to understand the nature of the illness and ongoing adherence to pharmacotherapy (Miklowitz and Axelson, 2008)
- **Group Therapy –** As asserted by a published research study conducted by APA (2002), Group psychotherapy may also help patients in addressing adherence to a treatment. Groups can provide useful information about bipolar dis- order and its treatment.
- **Cognitive Behavioral Therapy (CBT) -** Behavioral techniques efficacies like motivational enhancement and behavioral contingencies are used to treat bipolar disorder problems in children and elderly adult. It is strongest in treating anxiety disorders, somatoform disorders, bulimia, anger control problems, and general stress (Hofmann et al. 2012).
- **Interpersonal and Social Rhythm Therapy (IPSRT) –** This bipolar disorder treatment approach is used for adolescents and adults that have significant morbidity, mortality, and impairment in psychosocial and occupational functioning. It has been showed to help delay relapse, speed recovery from a bipolar depressive episode, and increase occupational and psychosocial functioning inadults with BD (Hlastala et al. 2010).

Model of Abnormality

Sue et al (2016) explains abnormal behavior as a model that highlights the impact of biological, psychological, social, and socio cultural factors in the development of

specific mental health. The biological dimension includes genetic. Abnormal brain processes are symptoms of spontaneous and perseverative nature. Neurophysiological, neuropathological, and neurochemical abnormalities have been discovered in bipolar disorder within the system that modulate abnormalities (Druvert et al. 2008).Syndromes with respect to pathophysiology and etiology have showed heterogeneity in bipolar disorder. Neuroimaging, neuropathological and lesion analysis studies show that brain networks regulate emotional behavior in the pathophysiology of mood disorders (Phillips et al.2003). A study conducted by Craddock and Jones (2005) depicts that lifetime prevalence of genetically developed bipolar disorder is 1% in families. Methodological impediments to precise quantification of bipolar disorder exist approximately in a lifetime with relatives of bipolar prob and which are: monozygotic co-twin 40-70%; first degree relative 5-10%; unrelated person 0.5-1.5% (Craddock and Jones, 2005).In contrast, molecular genetic positional and candidate gene approaches are being used for the genetic dissection of bipolar disorder although, no gene has yet been identified but promising findings are emerging (2005).

An empirical study of stimulant treatment was carried out to compare a certain demography of adolescent with the history of bipolar disorder. It was hypothesized that adolescents treated with stimulants would have an earlier age at onset of bipolar disorder, independent of co-occurring attention-deficit-hyperactivity disorder (ADHD). Thirty-four adolescents hospitalized with mania were assessed and age at onset of bipolar disorder and pharmacological treatment history, Results showed that bipolar adolescents with a history of stimulant exposure prior to the onset of bipolar disorder had an earlier age at onset of bipolar disorder than those without prior stimulant exposure. Results suggest that stimulant treatment, independent of ADHD, is associated with younger age at onset of bipolar disorder. The study also concluded that stimulant medications in children with or at genetic risk for bipolar disorder require future investigation (Del Bello et al. 2001).

In the research study of "Cognitive vulnerability in patients with bipolar disorder" by Scott et al. (2000), it was criticized that patients with cognitive vulnerability in bipolar disorder possess similarities with unipolar disorders. In clinical treatment, research into psychological models of affective disorder does not clearly show a dysfunction as cause or an effect of repeated episodes of bipolar disorder.

Conclusion

Long-term antidepressant (AD) treatment for depression in bipolar disorder patients is highly prevalent, but its benefits and risks remain uncertain. According to large scale of national survey, the lifetime prevalence for bipolar I is 1.0 percent and 1.1 percent for bipolar II, while the lifetime prevalence rate of cyclothymic disorder has a rating between 0.4 percent and 1 percent. Bipolar disorders have been found to be under diagnosed and as much as 10 percent people that are diagnosed with depressive disorders always end up with bipolar disorders. Researches carried out in the area of behavioral activation, interpersonal therapy, and cognitive-behavior have been instrumental in providing some level of support for the treatment of depression. In cases of severe depression, antidepressant medication have proven to be beneficial, although psychotherapies have showed to have a long lasting effect in the treatment of bipolar disorder. Further studies are required in the area of the biological model, considering the genetic frame up of the patients.

References

American Psychiatric Association. (2002). *Practice guideline for the treatment of patients with bipolar disorder (revision)*. American Psychiatric Pub.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.

Craddock, N., O'donovan, M. C., & Owen, M. J. (2005). The genetics of schizophrenia and bipolar disorder: dissecting psychosis. *Journal of medical genetics*, *42*(3), 193-204.

DelBello, M. P., Soutullo, C. A., Hendricks, W., Niemeier, R. T., McElroy, S. L., &Strakowski, S. M. (2001). Prior stimulant treatment in adolescents with bipolar disorder: association with age at onset. *Bipolar disorders*, *3*(2), 53-57.

Drevets, W. C., Price, J. L., & Furey, M. L. (2008). Brain structural and functional abnormalities in mood disorders: implications for neurocircuitry models of depression. *Brain structure and function*, *213*(1-2), 93-118.

Geddes, J. R., & Miklowitz, D. J. (2013). Treatment of bipolar disorder. *The Lancet*, *381*(9878), 1672-1682.

Goldberg, J. F., Perlis, R. H., Bowden, C. L., Thase, M. E., Miklowitz, D. J., Marangell, L. B., & Sachs, G. S. (2009). Manic symptoms during depressive episodes in 1,380 patients with bipolar disorder: findings from the STEP-BD. *American Journal of Psychiatry*, *166*(2), 173-181.

Gutierrez, M. J., & Scott, J. (2004). Psychological treatment for bipolar disorders. *European Archives of Psychiatry and Clinical Neuroscience*, *254*(2), 92-98.

Healy, D. (2008). *Mania: A short history of bipolar disorder*. JHU Press.

Hlastala, S. A., Kotler, J. S., McClellan, J. M., & McCauley, E. A. (2010). Interpersonal and social rhythm therapy for adolescents with bipolar disorder:

treatment development and results from an open trial. *Depression and anxiety*, *27*(5), 457-464.

Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive therapy and research*, *36*(5), 427-440.

Miklowitz, D. J., Axelson, D. A., Birmaher, B., George, E. L., Taylor, D. O., Schneck, C. D., & Brent, D. A. (2008). Family-focused treatment for adolescents with bipolar disorder: results of a 2-year randomized trial. *Archives of general psychiatry*, *65*(9), 1053-1061.

Phillips, M. L., & Kupfer, D. J. (2013). Bipolar disorder diagnosis: challenges and future directions. *The Lancet*, *381*(9878), 1663-1671.

Phillips M. L., Drevets W. C., Rauch SL, Lane R. (2003). Neurobiology of emotion perception II: implications for major psychiatric disorders. Biol Psychiatry 54:515–528. doi: 10.1016/S0006-3223 (03)00171-9

Scott, J., Stanton, B., Garland, A., & Ferrier, I. N. (2000). Cognitive vulnerability in patients with bipolar disorder. *Psychological medicine*, *30*(2), 467-472.

Sue, D., Sue, D. W., Sue, S., & Sue, D. M. (2015). *Understanding abnormal behavior*. Cengage Learning.

Vieta, E. (2005). Improving treatment adherence in bipolar disorder through psychoeducation. *The Journal of clinical psychiatry*, *66*, 24-29.